FINAL SUMMARY AND RESPONSE TO COMMENTS

Comment # 4

Commenter Name(s): ACIC
Date of comment: 11/10/04
Type of comment: Written

Summary of comment: ACIC contends that Section 2698.30(c), the definition of a claims handler, as written, arguably includes outside counsel retained by the insurer to litigate claims. ACIC feels the definition should be narrowed to exclude counsel involved in claims settlement or litigation.

Response to comment: The Commissioner does not agree with the commentator's contention. The commenter indicates that the insurers' attorney that is involved in claims settlement or litigation should be excluded from the definition of "claims handler". The Commissioner believe to the extent that a counsel is acting or functioning solely as a claims handler and is engaged in only in claims processing, insurer's counsel should b included within the proposed definition. It should be noted that where an insurer's counsel acts as counsel and such acts are those solely within the province of an attorney, applicable rules of statutory construction will apply and the insurer's counsel will not be considered as a claims handler.

Commenter Number

Commenter Name(s): ACIC, SCIF, ACLHIC, PIF, AIA
Date of comment:
Type of comment: Written

Summary of comments (Re: Section 2698.30 (k))

1. SCIF recommends that the expand the reference to claim or application to include; "to payment of denial of a claim or *application for adjudication of claims or application of insurance,*" and include "call center staff within the claims *or policy* function."
2. ACIC feels that the definition is too broad and argues that the State should not define the duties of insurance company clerical personnel
3. ACLHIC proposes to include agents in the definition. The commenter feels that this is contrary to the definition since an agent is very much involved in the processing of an application of insurance. An agent is the first line of defense from an insurance company.
4. PIFC recommends that a subsection be created to distinguish between property and casualty insurers and workers' compensation insurers. They also recommend deleting legal staff, policy/application handlers and underwriters from the definition
5. AIA contends that the definition is extremely broad, that it practically does not include all insurance company personnel involved in the day-to-day operation of an insurance company including those who do not have, nor should they have, access to information that would cause them to be able to identify within a "reasonable belief"

that fraud may have been perpetrated. If the definition purports to regulate all insurer personnel, it lacks authority and consistency with current code.

Response to comment:

1. The Commissioner accepts SCIF's comment and agrees with suggested changes that will read: "to payment of denial of a claim or *application for adjudication of claims or application of insurance,*" and include "call center staff within the claims *or policy* function." The Commissioner further agrees with this commentator that these minor changes provide additional clarity to the definition.

2.The Commissioner has considered and rejects ACIC 's comment that the inclusion of the examples of various staff position titles in the definition is overbroad for the purpose of achieving compliance with the Insurance Fraud Preventions Act. The Commissioner has purposefully drafted the definition of integral anti-fraud personnel based on the function and duties of such personnel in relation to claims and applications transactions and procedures and not solely on the insurer classification. The Commissioner believes that the definition as revised is clearer and easier to understand and will assist insurers in achieving compliance with the Insurance Fraud Preventions Act.

3. The Commissioner has considered and rejects ACHLIC's proposed regulatory language that includes insurance agents within the definition of "integral anti-fraud personnel" and no changes to the text will be made. The Commissioner agrees with the commenter that an agent is very much involved in the processing of an application of insurance and that an agent is the first line of defense against insurance fraud from an insurance company perspective. The Commissioner believes that it is more appropriate to address the issue requirement for fraud experience has already been addressed by the prelicensing education requirements set forth at California Code of Regulations Section 2186.-2187.4. The Commissioner believes that including fraud training within the producer licensing curriculum's existent structure is simpler and more efficient than including insurance Agents within the definition of "integral anti-fraud personnel".

4. The Commissioner has considered and rejected PIFC's recommended change to the definition of " integral anti-fraud personnel" where a distinction is made between property - casualty insurers and worker's compensation insurers for the following reasons. First, the Commissioner believes that if such a definition were to be adopted it would be too cumbersome and difficult to enforce. The Commissioner further believes that a two part definition would not be adequate for all lines of insurance as it only address two types of insurance rather than setting forth factors applicable to all lines. The Commissioner believes that is more appropriate to construct a flexible definition of "integral anti-fraud personnel" that is based on functions performed by personnel rather than the classification or job title assigned to them by the insurer.

The Commissioner has also considered and rejected PIFC's suggestion that in house legal staff, policy application handlers and underwriters be removed from the definition of "integral anti fraud personnel". The Commissioner has purposefully drafted the definition of integral anti-fraud personnel based on the function and duties of such personnel in

relation to claims and applications transactions and procedures and not solely on the insurer classifications or titles.

5. The Commissioner has considered and rejected AIA's comment that the proposed definition of "integral anti-fraud personnel "is overbroad. The inclusion of the examples of various staff position titles in the definition is based on their function and duties in relation to claims and applications transactions and procedures and is not based solely on the insurer classification. The insurer and not the individual integral anti-fraud personnel are required to establish the reasonable belief needed to make the referral of suspected insurance fraud as required in section 2698.37. However, the function and duties of the personnel mentioned in the definition are directly related to the points of a company's exposure to fraud and therefore must be included in the definition. The definition does not purport to regulate all insurer personnel and the Commissioner, ,therefore, believes it is unnecessary to respond to the assertion that the Commissioner lacks authority to promulgate this definition and that such definition is inconsistent with current code.

Commenter Number

Commenter Name(s): ACIC, PIFC

Date of comment:
Type of comment: Written

Summary of comment: Regarding section 2698.30(l)

1) ACIC believes that the definition of reasonable belief is a higher standard than that of reasonable suspicion and that this may narrow an insurer's immunity for reporting suspected fraud.

2) PIFC proposes to not change the definition of "reasonable belief" to "reasonable suspicion" as has been proposed by ACIC. PIFC feels this definition will encourage the submission of more cases with greater proof of suspected fraudulent activity.

Response to comment:

1. The Commissioner rejects ACIC's assertion that the standard for referral of suspected fraud to the Department should be "reasonable suspicion". The Commissioner has purposefully selected "reasonable belief" as the appropriate standard to be utilized for the referral of cases, as it requires that insurers who do refer cases to provide a greater level of proof of suspected fraudulent activity and ultimately, fosters a more efficient and appropriate use of the Commissioner's resources by requiring that the insurer provide an objective justification based on articulable facts and rational inferences therefrom that there may be insurance fraud before referral to the Fraud Division.

2. The Commissioner rejects ACIC's assertion that the proposed regulatory language may narrow or diminish current immunity standards. Immunity standards are prescribed by statute and are not diminished by the proposed regulatory language. However, to the

extent that this comment is a request for clarification of the relationship between the proposed regulation and current statutes regarding statutory immunity, a paragraph clarifying the existence of statutory immunity has been included in Section 2698.37, as subparagraph (d).

3. The Commissioner agrees with PIFC's assertion that the definition of reasonable belief in its proposed form is the appropriate standard to be utilized for the referral of cases, as it requires that insurers who do refer cases to provide greater proof of suspected fraudulent activity. In turn, use of such a standard, ultimately, fosters a more efficient and appropriate use of the Commissioner's resources by requiring that the insurer provide a an objective justification based on articulable facts and rational inferences therefrom that there may be insurance fraud before referral to the Fraud Division.

Commenter Number

Commenter Name(s): CSAA, SCIF, ACIC, ACLHIC, AIA
Date of comment:
Type of comment: Written and verbal

Summary of comment: 2698.30(p)

SCIF , The commentator recommends that the definition of suspected insurance fraud should be changed to read, " suspected insurance fraud" *is a reasonable belief, based on articulable facts*, that *an unlawful, material* misrepresentation of fact… The commenter feels that the current definition fails to take into account the statutory elements necessary to show the existence of fraud or the definition of "reasonable belief." The commenter also recommends changing the reference from "unusual policy activity" to "*suspicious* policy activity."

ACIC the commentator contends that this definition should either define actual or suspected insurance fraud.

ACLHIC – The commentator contends that this definition supports adding "agents" to "integral anti-fraud personnel" definition.

CSAA proposes to clarify the definition by adding, "suspected insurance fraud includes, *but is not limited to*, any misrepresentation…" and "*may includes other potential instances of insurance fraud*."

AIA – Asserts that "any misrepresentation of fact omission of fact" is overly broad. Also the disclosure of "premium and application fraud" lacks authority and consistency with current code.

Response to comment:

The Commissioner has considered the proposed the definition of "suspected insurance fraud" proposed by SCIF and rejects the proposed definition. The Commissioner has

purposefully not included "reasonable belief" in the definition of "suspected insurance fraud" as "reasonable belief" is the appropriate standard for referral of cases to the Fraud Division and not the standard to be utilized for the identification of "suspected insurance fraud".

The Commissioner also has considered and rejected the suggestion by SCIF that the definition of suspected insurance fraud should include the term "unlawful act" within the definition of suspected insurance fraud. This aspect of SCIF'S proposed definition, if adopted, would require that law enforcement become involved to make the determination of whether or not conduct is unlawful.

The Commissioner has considered and rejected the recommendation of SCIF to include the language "material" misrepresentation" within the definition of "suspected insurance fraud. The definition, as presently drafted, sets forth various categories of insurance transactions that may or may not rise to the level where "reasonable belief" is established and the insurer then becomes obligated to refer the matter to the Fraud Division. The addition of a "materiality"requirement to the definition of "suspected insurance fraud" is inappropriate it requires that the insurer makes a determination that a "material misrepresentation" has occurred and thus, imposes too rigorous a standard that insurers must meet in order to refer the suspected insurance fraud to the Fraud Division.

The Commissioner has also considered SCIF's recommendation to change the reference from "unusual policy activity" to "*suspicious* policy activity and rejects this suggestion as the term "unusual policy activity" is a broader term that includes within it "suspicious policy activity". The Commissioner believes that it is preferable to use the language "unusual policy activity" as this potentially may trigger an insurer's obligation to investigate in a larger number of insurance transactions than if the definition were restricted to "suspicious policy activity" where the activity must be suspicious (or give rise to a suspicion) in order to trigger the insurer's duty to investigate. The Commissioner believes that a broader (yet not unfettered) duty to investigate is preferable to a more circumscribed duty to investigate in order to ensure enhanced detection and deterrence of fraud.

The Commissioner has considered ACIC's comment that the definition of "suspected insurance fraud" appears to be a definition of actual fraud and rejects it. The definition of suspected insurance fraud provides a catalogue or listing of fact patterns that trigger an insurer's obligation to investigate. Actual fraud can be distinguished from the proposed definition of "suspected insurance fraud" as "actual fraud" requires not only misrepresentation of material facts, but intent, causation and damages.

The Commissioner has considered and accepted in part and rejected in part the suggestion of ACLHIC that the definition of suspected insurance fraud supports adding "agents" to "integral anti-fraud personnel" definition. The Commissioner agrees that agents are one of the first lines of defense against insurance fraud; however, after workshops with the industry it was determined that it would be preferable to exclude them from the definition of "integral anti–fraud personnel" as insurance agents have their own extensive prelicensing education requirements which contain curriculum

components regarding insurance fraud. [See California Code of Regulations, Section 2186.-2187.4]

The Commissioner has considered and rejected CSAA ‘s suggested language for insertion into the definition of suspected insurance fraud and rejects the suggested language. The Department feels that adding the terminology “but is not limited to” is not necessary as the definition as currently drafted provides for inclusion by the use of the word “includes”. The Commissioner believes the use of the word “includes” is clearer and simpler than the suggested includes but is not limited to” and conveys the same meaning. The Commissioner also rejects the suggestion of CSAA that the language “potential instances of insurance fraud” be inserted into the definition of “suspected insurance” fraud as it is undefined term and vague and reduces the clarity of the definition.

The Commissioner has considered and rejected AIA‘s comment that there is no Authority for the inclusion of application and premium fraud within the definition of suspected insurance fraud. Authority for inclusion of these specific frauds can be found at Insurance Code Sections 1871(f) and 1877.3.

Commenter Number

Commenter Name(s): Zenith, SCIF, ACIC
Date of comment: 11/01/04, 11/05/04, and 11/10/04, respectively
Type of comment: Written

Summary of comment: 2698.32(a)
1. Zenith, does not agree that numbers of claims, insureds, number of staff or the percentage of fraud should be used in the definition to demonstrate adequacy of staff and that each company should determine their staffing levels

2. SCIF proposes that there be quantifiable criteria to the factors for assessing staffing adequacy including the number of policies and insureds or the volume of suspected fraudulent claims.

3. ACIC definition fails the “clarity” test of the APA is probably unenforceable as anything more than a general statement of regulatory intent.

Response to comment:

1. The Commissioner has considered and rejects Zenith’s contention that the factors listed are outdated and or erroneous factors with measuring the adequacy of the SIU staff. This proposed section provides insurers with a nonexclusive list of factors to determine when a SIU is adequately staffed to perform the functions required by these regulations. These factors are related to the amount of suspected insurance fraud that can reasonably be expected by an insurer. Adequacy of staffing is ultimately dependent on whether the insurer can demonstrate an ability to establish, operate and maintain an SIU that is in compliance with these regulations.

2. The Commissioner has considered SCIF's objection and suggestion that the definition of "adequacy" contain quantifiable criteria for a determination of adequacy. The Commissioner has considered and rejected this suggestion as the proposed section provides insurers with a nonexclusive list of factors to determine when a SIU is adequately staffed to perform the functions required by these regulations. The factors listed within the proposed definition of are some suggested measures that are sufficiently flexible in their current form to allow insurer's the discretion to select the best performance measurement to determine staffing levels. It should also be noted that during public workshops that preceded the promulgation of these regulations insurance industry representative opposed the use quantifiable criteria as such criteria unnecessarily invite comparisons between insurers that can be misleading. For the foregoing reasons the Commissioner believes that the regulation, as drafted, provides sufficient guidance as to what conduct is expected of insurers and will not to insert more rigid (quantifiable) criteria as he believes flexible criteria are more appropriate and easier for the regulated entity to comply with.

3. The Commissioner has considered ACIC's comment that Section 2698.32 (a) fails to meet the clarity standard as set forth at California Government Code Section 11349(c) and rejects this comment. The commentator has not developed this comment to the extent that the Commissioner is able to understand how the proposed language is not easily understood by those directly affected and further disagrees that it is merely a statement of regulatory intent as it clearly states what is required of an insurer and factors that may be considered to determine if the insurer has complied with the requirement.

Commenter Name(s): SCIF, ACHLIC. AIA
Date of comment:
Type of comment: Written

Summary of comment: 2698.32(b)

1. SCIF – add the words "and policy practices " to the language of 2698.32(b) so that the subsection will read: An SIU shall be composed of employees who have knowledge and experience in general claims and policy practices….
2. ACHLIC – wants to change "knowledge and experience" to "knowledge and/or experience.

3. AIA – The commenter contends that the requirement that phrase "be familiar with the use of available insurer related database resources" lacks necessary regulatory clarity. The commenter also contends that insurers would think this term ambiguous and that it could not know if its employee met the standard. The commenter also contends that the section lacks authority as it would prohibit the employment of many people in the SIU particularly, law enforcement personnel. The commenter takes issue with the requirement that all SIU staff be familiar with insurance fraud and insurance claims, contending that this prohibits the hiring of former law enforcement personnel.

Response to comment:

The Commissioner has considered SCIF's comment to add the words "and policy practices" to subsection 2698.32(b) and rejects such an amendment for the following reasons. The function and focus of the SIU is the deterrence and detection of fraud. "Policy practices "is not a defined term within the enabling statutes and does not further the Commissioner's objective of creating effective SIUs.

The Commissioner has considered and agrees with the ACLHIC's recommendation to add the word "or" so that the proposed section reads: "An SIU shall be composed of employees who have knowledge/and or experience…" The Commissioner believes the recommended change allows the insurer great flexibility with respect to the staffing and allows for the hiring of staff with sufficient knowledge/and or experience in the key areas of fraud detection and deterrence.

The Commissioner has considered and rejected AIA 's objection to section 2698.32(b) As discussed above in response to ACHLIC objection to this subsection the word "or" has been added to the subsection and the addition of the word "or" to the subsection does allow the insurer to employ former law enforcement personnel within the SIU.

The Commissioner has also considered and rejected AIA 's contention that the phrase "be familiar with the use of available insurer related database resources "lacks necessary regulatory clarity". "Clarity" is defined in the California Government Code as written or displayed so that the meaning of the regulations will be easily understood by those persons directly affected. While the phrase" be familiar with the use of available insurer related database resources" may be somewhat vague and ambiguous to the general public, insurers who are subject to these regulations are a different audience that either knows or should know of these databases. Further, the Commissioner has purposefully declined to specifically name databases so that there is no implied endorsement of one database over another.

Finally, the Commissioner has considered and rejected AIA's pro forma objection to subsection 2698.32 that the Commissioner lacks authority to promulgate this subsection as originally proposed. The Commissioner believes that there is ample implied authority (as indicated by the statutes cited in the note following the subsection) to promulgate this subsection both in the original and amended form.

Commenter Number

Commenter Name(s): ACIC, AIA
Date of comment:
Type of comment: Written

Summary of comment: 2698.33(a)

Regarding section 2698.33, general, AIA questions the statutory authority for dictating the terms or requirement of those contracts

ACIC wants to add “to assure compliance” under these regulations for clarification of TPA contracts

Response to comment

The Commissioner has considered and rejects AIA‘s comment that the Commissioner lacks statutory authority to dictate the terms or requirements of insurer contracts with entities that perform SIU functions. Pursuant to California Insurance Code Sections 12921(a) and 12926 the Commissioner has ample implied authority to enforce each enabling statute that serves as authority for these regulations. It is a well established principle of regulatory law that when an enabling statute is broad, the administrative agency may properly fill in the details by providing a detailed regulatory scheme to ensure that the underlying statute can be fully and properly enforced. The enabling statute doe not need to specifically authorize and delineate each proposed provision In the instant case, the provisions promulgated as 2698.33 (a)-(c), inclusive, are essentially clarification and delineation of the insurer’s existent duty to comply with the statute and the non–delegable duty an insurer to ensure that all regulations concerning the proper operation of a Special Investigations Unit are fully complied with. They do not seek to enlarge upon the cited statutes grant of implied authority.

The Commissioner has considered and rejected ACIC’s proposed amendment that Adds the language “to assure compliance” with these regulations” as the Commissioner believes that the addition of the proposed language does not provides any additional clarification.

Commenter Number

Commenter Name(s): SCIF, ACIC, Zenith
Date of comment:
Type of comment: Written

Summary of comment: 2698.34(b)

1. SCIF – wants to change “specific” incident of insurance fraud to “suspected”
2. ACIC – the commenter feels that once the insurer has complied with a request for information that the obligation should be deemed fulfilled even if multiple requests from other agencies ensue. Responding to excessive requests creates a burden on insurers. The commenter feels that the department should be the control repository of information.
3. Zenith – Feel it is overly burdensome to identify so many documents citing time consuming due to voluminous paper. The commenter also contends that this section “cut corners” by no longer having the State investigator identify which items would be needed to prosecute a case and instead asks for every possible document and writing having to do with, not only the claim, but the policy. The commenter sees no evidentiary value for a “history of claims.” The commenter proposes to change “shall” to “can include.”

Response to comment:

The Commissioner has considered and rejects SCIF's proposed change of the word "specific" to the word "suspected" and rejects the suggested change. The Commissioner believes that the regulation as drafted is preferable as "specific incidents" is the language that is used in the following enabling statutes. For these regulations: California Insurance Code Sections 1873(a), 1874.2(a) and 1877.3. The Commissioner believes the terminology used provides a more consistent and easier to understand regulation if the statutory language is consistent with regulatory language.

The Commissioner has considered and rejects ACIC's suggestion that the Department of Insurance should be the repository for information available to other agencies based on the Department's request for insurer information. The Commissioner rejects this comment. The Department of Insurance's purpose is not to be a repository of criminal investigation information to be available at the request of other agencies who are not participants in the Department's investigations. This proposal is outside the scope of these regulations as well as the enabling statutes and will not be addressed.

The Commissioner has considered and rejects Zenith's comment that the proposed subsection 2698.34(b) is overly burdensome in that it requires the insurer to identify too many documents and that this section "cut corners" by no longer having the Department identify which items would be needed to prosecute a case and instead asks for every possible document and writing having to do with, not only the claim, but the policy. The Commissioner has specifically drafted this subsection so that is broad in scope and so that the breadth of the records required will allow the investigator to most efficiently determine the extent of the fraud which may be beyond the scope of a single insurer, insured or party to the loss.

Further, the Commissioner has considered this commentator's objection that insurers should not be required to provide claims history as it has "no evidentiary value" is not persuasive as the Legislature has specifically required that insurers provide claims history in both California Insurance Code Sections 1873(a) and 1874.2(a).

Finally, the Commissioner has considered and rejected Zenith's argument that the language of this subsection 2698.34(b) should be changed from the mandatory language of "shall include" to the permissive language of "can include".

Commenter Number #2, 4

Commenter Name(s): SCIF, ACIC
Date of comment: 11/05/04, 11/1004, respectively
Type of comment: Written

Summary of comment: Regarding section 2698.34(c)

1. SCIF – Proposes to change time period to 30 days in keeping with 1877.3(d) and to add upon "the receipt of" the request to the text.

2. ACIC – Proposes to add that the timely release of information shall occur after "receipt of" the request.

Response to comment:

1. The Commissioner has considered SCIF's comment that proposes changes to subsection 2698.34(d) .SCIF proposed to change the time period within which an insurer must provide requested information to either the Fraud Division or an authorized governmental agency from 21 days to 30 days. The Commissioner agrees that in order to ensure consistency with California Insurance Code Section 1877.3(d) this text should be changed. The text will be changed to read, "For the purpose of this section, timely release of information means immediate*, but no more ~~than twenty-one (21)~~* thirty (30) *calendar days after the request* unless otherwise agreed to by the Fraud Division."

   The Commissioner has considered and rejected SCIF's suggestion to add "upon the receipt of" to text as the Commissioner believes the existing language is sufficiently clear to advise the insurer of the timeframe within which to provide the information.

Commenter Number #1, 2, 4, 5 and 6

Commenter Name(s): Zenith, SCIF, ACIC, ACLHIC and AIA, respectively
Date of comment: 11/01/04
Type of comment: Written

Summary of comment: Regarding section 2698.34(d)
1. SCIF – Proposes to:
   (a) add "received by" designated contact,
   (b) delete "and subsequent" to require production from,
   (c) add "the records of " all persons, and
   (d) add "to the extent that such records are in the insurers possession", end of paragraph text, and
   (e) SCIF also makes an argument regarding the practical use of a single point of contact as it does not assign responsibility for notification of various authorized agencies involved in the investigation of suspected fraud. Nor does it address situations where an authorized agency neglects to properly direct a request to a designated contact person.
2. Zenith proposes to remove text regarding the "single point of contact" as the current Department form already contains a line asking for a "contact person" and that routing requests to a single point of contact will require additional insurer time to provide a response.
3. ACIC states that having the "single point of contact" for the insurer is unnecessary micromanagement. They indicate that the existing procedure for requesting information is routine and continual between insurers and the Fraud Division. They also indicate that the language does not address the department's actions should a request be sent to the incorrect individual. ACIC compares the outcome of requiring both the insurer and the Department to have a single point of contact.

4. AIA contends that the current authority does not authorize such a broad grant of authority for demanding disclosure of any information. AIA also feels that this text is inconsistent with other statute such as the Insurance Information and Privacy Protection Act which requires insurers to keep certain information confidential.
5. ACHLIC proposes to change a single written request to "a designated contact person" to "the designated contact person".

Response to comment:

The Commissioner has considered and accepts the comments offered by Zenith, SCIF, ACIC and ACLHIC (as summarized above) regarding various difficulties inherent in the requirement imposed by subsection 2698.34(d) for the designation of a person with the SIU to serve as a contact person. The Commissioner agrees with the overall opinions of the commentator's that the additional requirement for a single point of contact to receive written requests from authorized governmental agencies is not practical and creates additional burdens on the insurers and the Department. Accordingly, the Commissioner has deleted the entire first sentence from the text of 2698.34(d) and has completely eliminated this requirement for a designated contact person. For consistency the language "to a designated contact person" has been eliminated from the second sentence of the subsection as well.

This portion of the text has been revised and shall read,"~~*The insurer shall designate a person within the SIU to serve as a contact person to receive written requests from authorized governmental agencies*~~. A single written request ~~*to a designated contact person within the SIU*~~ shall be considered sufficient to compel production of all information.

The Commissioner has considered the comment offered by SCIF regarding the second sentence of proposed section 2698.34(d) and will modify the text as suggested by SCIF; the revised text will now read: production of the requested records by the insurer named in the request and the records of all persons, agents and brokers employed by an conducting business on behalf of the insurer.

The Commissioner has considered SCIF's suggestion to delete "and subsequent to" from the text of section.2698.34(d). The Commissioner has deleted the suggested language; however, the Commissioner disagrees with SCIF's assertion that the Commissioner is not empowered to compel production of records by the use of one single request. The Commissioner is fully authorized by the plain meaning of the language of California Insurance Code Section 1877.3 to obtain the requested information. To provide further clarity the Commissioner has added a final sentence to subsection 2698.34(d) that clearly delineates that the single request is applicable throughout the duration of the investigation.

The Commissioner has considered and rejected SCIF's request that the words "to the extent that such records are in the insurer's possession" be added to the final sentence of 2698.34(d). The Commissioner has considered SCIF's suggested language and believes that such words of limitation are inappropriate here. The information in possession of the

TPA belongs to the insurers as the work performed was done on a contracted basis for the insurer. In short the insurer is in contractual privity with the TPA and the insurer has direct access to this information.

Regarding section 2698.34(d), the Department agrees with the overall opinions of the commentator's that the additional requirement for a single point of contact to receive written requests from authorized governmental agencies is not practical and creates additional burdens on the insurers and the Department. This language will be deleted.

Additionally, upon reading subparagraph again, the Department felt that the sentence structure made the paragraph unclear to the reader. Therefore, the paragraph has been restructured and reworded, slightly, to provide additional clarity and understanding. The paragraph now reads:

(d) ~~*The insurer shall designate a person within the SIU to serve as a contact person to receive written requests from authorized governmental agencies.*~~ A single written request ~~*to a designated contact person within the SIU*~~ shall be considered sufficient t o compel production of all information deemed relevant by the requesting governmental agency relating to any specific insurance fraud investigation. ~~at the time the request is made and subsequent to require production of the requested records by the insurer named in the request and the records of all persons, agents and brokers employed by and conducting business on behalf of the insurer.~~ The single request is applicable throughout the duration of the investigation and is applicable to the requested records of the insurer named in the request and the records of all persons, agents and brokers employed by and conducting business on behalf of the insurer.

Commenter Number

Commenter Name(s): PIFC
Date of comment:
Type of comment: Written

Summary of comment: Regarding section 2698.34(e)
The commenter proposes to "undelete" the proposed language that reads: "(e) Nothing in these regulations in intended to limit the confidentiality of these documents or other information provided by the insurer or other reporting entity, or the immunity thereof."

Response to comment:
Several commentators including PIFC, ACIC and CSAA have submitted recommendations regarding the subject of adding regulatory language that addresses immunity and confidentiality. The Commissioner has listened to the commentators collective concerns and recognizes that additional clarity regarding the statutory provisions regarding the confidentiality and immunity protections for submitting investigative records as required in the Insurance Frauds Prevention Act is needed. Therefore, the Commissioner accepts these commentators comments and will include regulatory language in section 2798.37(d) and (e) to read as, "(d) The requirements of this section do not affect the immunity granted under California Insurance Code section

1872.5 or other such similar codes contained in the Insurance Frauds Prevention Act and (e) The requirements of this section do not diminish statutory requirements contained in the Insurance Frauds Prevention Act regarding the confidentiality of any information provided in connection with an investigation".

Commenter Number #2, 4, 5

Commenter Name(s): SCIF, ACIC and ACHLIC
Date of comment: 11/05/04, 11/10/04 and 11/10/04, respectively
Type of comment: Written

Summary of comment: Regarding section 2698.35(b)

1. SCIF recommends narrowing the subsection to charge the SIU with monitoring only specific anti-fraud procedures rather than all procedures that may be used by integral anti-fraud personnel.
2. ACIC recommends that the requirement for "written" procedures be clarified or expanded to allow for other formats and storage options.
3. ACHLIC argues that this section, included subparagraphs (a)-(c), lends itself to including "agents" as integral anti-fraud personnel as defined in section 2698.30(h)
   (a) (b), the commenter feels that the last sentence reads as though the listing of red flags is all inclusive and that an all inclusive list cannot be put together. They recommend that the last sentence read "shall include a listing of possible red flags to be used."

Response to comment:

1. The Commissioner has considered SCIF's suggestion to narrow the scope of subsection 2698.35(b) to "specific anti-fraud procedures" rather than procedures applicable to all "integral anti- fraud personnel" and rejects the recommendation. The Commissioner believes that the subsection is already sufficiently narrow as drafted and that the subsection clearly indicates by the language used that it is applicable only to the anti-fraud procedures that are needed to support the purpose and investigative activities of the SIU.

2. The Commissioner has considered ACIC's comment suggesting that language be added to subsection 2695.35(b) which addresses all acceptable types of "written" format and document storage" and rejects this comment. The Commissioner has drafted these regulations using the plain English meaning of the word "written" to connote that procedures may not be imparted orally. The Commissioner believes that this subsection is necessary to ensure that all insurers have adequate, clear and guidance as to the conduct that is expected of them. Further, in recognition of the speed at which technology advances, Commissioner has not specifically limited or excluded other formats or excluded other forms of storage that may be used as technology develops. The Commissioner believes the subsection is clear as written and it can be readily understood by those who are subject to it, and will not revise it at this time.

3(a). The Commissioner has considered ACIC's comment that the procedures for detecting suspected fraud set forth at subsection 2695.35 (a)-(c) suggest that "insurance agents" should be included in the definition of "integral anti fraud personnel" and rejects it For the rationale underlying the rejection of this comment see final comments for section 2698.30(h) at Page 3.
3(b). The Commissioner has considered ACHLIC's comment that the language used in subsection 2698.35 implies an inclusive and final list of red flags. The Commissioner rejects ACHLIC's comment and believes that the text is clear and does not imply an inclusive and final listing of red flags. Notably, the paragraph, as presently written, provides that the SIU shall "maintain" the procedures used. The use of the word "maintenance" connotes that these procedures will be kept up to date and is subject to revision. All elements of the procedures including the listing of red flags are subject these revisions.

Commenter Number #2

Commenter Name(s): SCIF, ACHLIC
Date of comment: 11/05/04, 11/10/04
Type of comment: Written

Summary of comment: Regarding section 2698.35(c),
1. SCIF believes proposed subsection 2698.35 (c) is ambiguous and does not add useful detection criteria for the investigation of insurance fraud.
2. ACHLIC proposes to change "any insurance transaction" to reflect claims transactions only.
3. ACHLIC, expresses concern that the language "identification of patterns or trends of possible fraud" set forth at subsection 2698.35(c)(1) imposes a significant challenge for a life company due to the nature and variety of fraud issues faced versus issues faced by property and casualty companies.

Response to comment:
1. The Commissioner has considered SCIF's comment that subsection 2698.35 (c)(3) is ambiguous and does not add any useful detection criteria for the investigation of insurance fraud. The Commissioner rejects this comment as subsection 2698.35(c)(3) provides for the comparison of events and circumstances present on a claim. These factors enumerated in this subsection may be valuable in detecting insurance fraud in situations where the events presented in a claim require further examination because they are so unusual as to raise suspicion. For this reason the Commissioner rejects this commentator's contention that the subsection does not add any useful detection criteria. Further, although this commentator opines that this subsection is ambiguous, the Commissioner believes that it meets the clarity test imposed by California Government Code 11349 as it can be readily understood by the persons that are subject to the provisions of the regulation.

   2. The Commissioner has considered ACHLIC's proposal to change the language of subsection 2698.35 from "any insurance transaction" to "claims transactions". The Commissioner rejects this suggested change and has made no change as the

Commissioner believes that the ACHLIC's language is too restrictive. If such language were adopted, the scope of an insurer's duty to detect suspected insurance fraud were be seriously diminished and the Commissioner would not be fulfilling his statutory obligation to full enforce the law requiring the referral of suspected insurance fraud as required by, inter alia, California Insurance Code Sections 1875.20,1875.21,1875.22,1875.23, and 12921 and 12926. Additionally, the Commissioner recognizes that indications of suspected insurance fraud are not limited to claims transactions and believes the subsection as drafted provides insurers the maximum flexibility when determining the source of indicators of fraud.

We do not necessarily agree with the commenter's concerns. There were no proposed changes submitted and no response is required.

Commenter Number #1, 4, 5

Commenter Name(s): Zenith, ACIC, ACHLIC, PIFC
Date of comment: 11/01/04
Type of comment: Written

Summary of comment: 2698.36(a)

1. ACIC comments that the requirement imposed by 2698.36 (a) is excessive, and proposes to change the text to indicate that an investigation of possible suspected insurance fraud shall include "where appropriate and necessary…"
2. ACIC – Regarding section 2698.36(a) (1) ACIC feels a thorough "analysis" of a claims file is not required, feels a thorough "review" is sufficient accomplish the objective.
3. ACIC – Proposes to change the word "conclusion" to "finding."
4. Zenith –The commenter proposes to delete section 2698.36(a) (5) from the text. The commenter feels that the text, in its current form, attempts to force insurance company employees to arrive at decisions that should be made by prosecutors and then to document those decisions in writing – all without additional indemnity from civil litigation.
5. ACHLIC – 2698.36(a)(3) the commenter is concerned with the required "utilization of industry-recognized databases" as they remain unaware of such databases specifically geared toward life companies
6. PIFC – regarding 2698.36(a) (5) the commenter recommends the section be amended to add the word 'findings" to make the paragraph consistent.

Response to comment:

1. The Commissioner has considered and rejected ACIC's recommendation to change the text of 2698.36(a) to provide that an investigation of possible suspected insurance fraud shall include "where appropriate and necessary" the items listed in (1)-(6). The Commissioner believes that to add such words of limitation to this subsection would result in a situation where the insurer is allowed to determine what elements of an investigation they wish to undertake. This could potentially result in inadequate investigation of a suspected insurance fraud and ultimately result in inadequate level of

referral of cases to the Fraud Division or law enforcement. The commenter notes that this regulation contains no specific reference the steps an insurer must take to conclude an investigation if the insurer makes a determination the investigation. The Commissioner has considered this objection and rejects it as California Insurance Code Section 1872.4(b) sets forth the procedure to be followed when concluding an investigation and is outside the scope of these regulations.

2. The Commissioner has considered ACIC‘s comment that thorough “analysis” of a claims file is not required and that a thorough “review” is sufficient to accomplish the objective. The Commissioner has considered this comment and rejects it. The Commissioner believes that a thorough analysis of a particular transaction is required to make the necessary determination regarding whether or that transaction rises to the level of suspected fraud. We feel that investigation of suspected fraud requires more than a mere review to make a determination that will meet the department’s objective.

3. The Commissioner has considered and accepted ACIC’S recommendation and the word “conclusion” will be replaced with “finding” to make the paragraph language consistent. The text will read, “Writing a concise and complete summary of the investigation, including the investigator’s ~~conclusions~~ findings regarding the suspected insurance-fraud and the basis for their ~~conclusions~~ *findings”.*

4. The Commissioner has considered Zenith’s proposal to delete section 2698.36(a) (5) from the text and rejects this proposal. A synopsis of the suspected fraud does not require legal conclusions and findings from the insurer. The Commissioner agrees with the commentator’s contention that it is the prosecutor’s job to determine if sufficient evidence is present to support a criminal filling. The insurer does not determine the probable cause necessary to initiate a criminal filing but does make the initial determination of suspected fraud necessary to compel further investigation and ultimately referral to the Department. The establishment of reasonable belief is more that a mere hunch but does not have to rise to the level of probable cause.

5. The Commissioner has considered and rejects ACHLIC’s comment that they are unaware of any industry recognized data bases for the life insurance industry. There are no changes as a result of this comment. The regulations are written to apply to all lines of insurance and any specificity is clearly designated in the text. Each insurer bears its own responsibility for awareness and utilization in regards to databases applicable to its business. The regulations establish minimum, consistent procedures for the investigation of possible suspected insurance fraud; each insurer SIU must determine the most applicable procedures for its business requirements.

6. The Commissioner has considered PIFC's comment that subsection 2698.36(a)(5) be amended to add the word “findings” to make the paragraph consistent. The Commissioner accepts the comment and the text will be revised as indicated above in response number 3.

Commenter Number

Commenter Name(s): CSAA,
Date of comment:
Type of comment: Written

Summary of comment: 2698.37 general comment

CSAA proposes to provide clarity regarding reporting immunities by adding language that states, "The requirement of this section do not affect the immunity granted under California Insurance Code section 1872.5."

Response to comment: The Commissioner has considered and accepts CSAA's recommendation to provide clarity regarding immunity and the referral process. However, there are a number of immunity references contained in the Insurance Frauds Prevention Act including Sections 1872.5, 1873.2, 1874.4, 1874.6, 1875.4, 1877.5, and 1879.5. Text will be added in the form of subparagraph 2698.37 (d) that will read: "*The requirements of this section do not affect the immunity granted under California Insurance Code section 1872.5 or other such similar codes contained in the Insurance Frauds Prevention Act*."

Commenter Number

Commenter Name(s): #5
Date of comment: ACHLIC
Type of comment:

Summary of comment: In reference to the referral of suspected insurance fraud to district attorneys, the commenter would like to see clarification as to the type of cases/scenarios and when reporting to district attorney's would be required.

Response to comment: No change has been made. This regulatory text provides for the referral of suspected insurance fraud to the Fraud Division and, "as required", district attorneys, is in reference to reporting requirements contained in CIC section 1877.3. This statutory language requires referrals of suspect workers compensation fraud to be made to the Fraud Division and district attorneys.

Commenter Number #4

Commenter Name(s): ACIC
Date of comment: 11/10/04
Type of comment: Written

Summary of comment: Regarding section 2698.37(b) the commenter recommends that a referral be made when there is a "reasonable suspicion" rather than a "reasonable belief."

Response to comment:

The Commissioner has considered ACIC's comment that the use of the term "suspicion" as opposed to "belief" is consistent with statute that describes when the referral process should take place. The Commissioner rejects this comment on the grounds that CIC Sections 1872.4, 1874.2, 1877.3 and 1879.5 all use a form of the term "belief" and not suspicion.

Commenter Number

Commenter Name(s): ACIC, ACHLIC, Employer's Insurance Group (EIG)
Date of comment:
Type of comment: Written and Oral

Summary of comment: 2698.37(c)

ACIC contends that there is a potential conflict between this California Insurance Code Section (1872.4(a)) that requires referrals be made with the statutory 60-day period and Civil Code 1708. 8 that requires and insurer to have an "articulable suspicion" before embarking on surveillance. Their argument is that an "articulable suspicion" triggers the 60-day reporting requirement even in cases where additional evidence of illegal activity has not been fully documented.

Employers Insurance Group–The commenter argues that the timing required for making a referral (60 days) and Civil Code section 1708.8 that requires "articulable suspicion" before commencing surveillance. The commenter has been advised by legal counsel that a referral must be made due to the "articulable suspicion" but that it can occur before a confirmed suspicion of fraud has been made by the completed surveillance.

ACHLIC – The commenter does not believe that referrals should be limited to a period specified by statute and that the referral should be made using the State of California Form referenced.

Response to comment:

1. The Commissioner has considered ACHLIC's and EIG's comment that there is a conflict between the statutory section that requires referrals be made with the statutory 60-day period (1872.4(a)) and Civil Code 1708.8 that requires insurers to have an "articulable suspicion" before embarking on surveillance. The Commissioner rejects this comment and no change to the regulatory text has been made for the following reason. Section 2698.37(b) provides, "referrals shall be submitted in any insurance transaction where the facts and circumstances create a reasonable belief that a person or entity may have committed or is committing insurance fraud." Further, Section 2698.30(i) provides that, "reasonable belief is a level of belief that an act of insurance fraud may have or might be occurring for which there is an objective justification based on articulable fact(s) and rational inferences there from." The Commissioner believes that the articulable suspicion that precipitates a 1708 tape

does not necessarily rise to the level of reasonable belief if the articulable fact(s) and rational inferences are not be established until the tape is made.

2. ACHLIC comments that referrals should not be limited to a period specified by statute. The Commissioner has considered and rejected this suggestion, as the Commissioner is not empowered to enlarge upon or disregard these time periods without exceeding the implied authority conferred upon him by statute. California Insurance Code Sections 1877.3 and 1872.4 specify statutory time limitations within which referrals must be made. The Commissioner accepts this commentator's comment that referral should be made pursuant to subsection 2698.38; however, the Commissioner will make no change to text based on this comment, as the comment requires no further revision of text.

The Commissioner has also considered this commentator's comment that the statutory requirements regarding referral be set forth in the referral form. And we found no compelling justification to repeat the statutory requirements in this section. The Commissioner believes the manner in which the form is presently formatted is clear and easily understood by the regulated insurers and that further modification is unnecessary.

Commenter Number

Commenter Name(s): ACIC
Date of comment:
Type of comment:

Summary of comment: 2698.38(d)

1. ACIC contends that the amount of information required to refer suspected fraud appears to be unduly comprehensive given the early state of the investigation at which a referral is made. The commenter recommends that, at a minimum, a referral of suspected insurance fraud should be required to contain the specified data"…to the extent such information is material and reasonably available to the insurer. Proposes to change to information is "material and reasonably available" rather than "applicable" as indicated in the regulations.

2. The commenter proposes to change "reasonable belief" to "reasonable suspicion" as it imposes a higher duty on insurers than currently required by statute and has the effect of narrowing the immunity from liability.

Response to comment:

The Commissioner has considered ACIC's contention that requirements for a referral of suspected insurance fraud constitutes an unduly comprehensive request for information. The Commissioner has considered this comment and rejects it. The Commissioner believes that the information requested accurately reflects the information needed by the Fraud Division to process the referral. A significant problem with the originally promulgated regulations regarding Special Investigative Units was that they provided insufficient guidance to insurers as to when it was appropriate to refer suspected insurance fraud to the Fraud Division. The regulations proposed herein seek to address

that situation and provide a clear, uniform and yet flexible standard that an insurer must use to determine if there is sufficient evidence for referral.

The Commissioner has also considered this commenter's suggestion that subsection 2698.38 be revised to delete the words "to the extent applicable" and modify the language so that it reads" to the extent such information is material and reasonably available" and rejects the suggested change. The Commissioner

And has determined the word "applicable" should remain in the subsection as it is plain English capable of being understood by the regulated entities. Further, the Commissioner believes that since insurer's records are, the primary source of evidence and the absence of any reported information could jeopardize the initiation of a case investigation, impede the progress of an investigation and ultimately hinder successful prosecution deletion of the general word "applicable" and replacing it with the highly subjective and limiting phrase "material and reasonably available" is an unacceptable alternative. The suggested language contains words of limitation that would allows an insurer the latitude to provide selected portions of the requested information listed on the referral according to its own parameters. Further, the Commissioner has considered the use of the word "material" within this definition is not appropriate as the word used is a word of limitation and requires a subjective judgment that should be made by law enforcement personnel rather than insurers. Finally, the Commissioner also rejects the use of "reasonably available" as it allows the insurer to limit the information provided in a referral within their own parameters. As set forth in the Statement of the Public Problem, the originally promulgated regulations provided insufficient guidance provided to insurers as to when to refer suspected insurance fraud to the Fraud Division. The regulations proposed herein seek to address that situation and provide a clear, uniform and flexible standard that an insurer must use to determine if there is sufficient evidence for referral.

The Commissioner has considered and rejects the comments regarding subsection 2698.37 (b) and the standard the term "reasonable belief". The use of the term "belief" as opposed to "suspicion" is consistent with statute that describes when the referral process should take place. CIC sections 1872.4, 1874.2, 1877.3 and 1879.5 all use a form of the term "belief". In regarding to concerns regarding immunity, a new section, 2698.37(e) has been added as a result of similar comments received.

Commenter Number

Commenter Name(s): SCIF, AIA, ACIC, ACHLIC, PIFC
Date of comment:
Type of comment: Written

Summary of comment: 2698.39(c)

1. SCIF – The commenter recommends adding SIU phone list on subparagraph (c)(1)(d)
2. SCIF – on subparagraph (c) (2) recommends that integral anti-fraud personnel get annual training from 90-day of commencing the qualifying work assignment.
3. AIA – The commenter contends that the training requirement is too broadly applicable, unreasonable expectation

4. ACIC – The commenter feels that the training requirement is too broadly applicable, too costly and that this is regulatory micro-management that serves no valid purpose.
5. ACHLIC, Regarding section 2698.39(c)(3)(d), the commenter refers to required training that includes "emerging fraud trends" and indicates that they view the identification of, and any training regarding, fraud trends within the life industry to be a significant challenge.
6. PIFC – The commenter indicates that it was their understanding from previous conversations with the CDI that the intent of the Fraud Division is to make sure that all newly hired insurance personnel receives 'material" during their orientation that explains the role and function of the company's fraud unit. They would like to clarify that the orientation be provided in the form of a packet of information and that references to the term "orientation" be deleted and replaced with "material.' Additionally, the commenter proposes to delete subparagraph (c) and modify subparagraph (b) to read, "An overview of the fraud detection and referral of suspected fraudulent claims."

Response to comment:

1. SCIF – The Commissioner has considered and accepts SCIF's recommendation to add SIU telephone information to subparagraph (c) (1). This recommendation is in keeping with the intent of this subsection that is for the insurer to provide general information regarding insurance fraud and what all new staff should know about handling incidents suspected insurance fraud. The text will be revised to add a subparagraph (e) "SIU contact telephone number(s)"

2. SCIF – The Commissioner has considered and has rejected the additional changes recommended by the commenter. The regulatory training requirements establish minimum levels for training of insurer's staff and the retention applicable training documentation. The commenter raises good business practices for more specific training protocols; however, the Commissioner believes that proposed the recommendations are unnecessary.

The Commissioner agrees with the commenter's suggested change that the training of integral anti-fraud staff receive training "within 90 days of receiving assignment". However, the suggested language for inclusion in 2698.39(c) (2) "and annually thereafter" is not included in this amendment as the Commissioner believes it would be duplicative language as 2698.29(c) (2) as presently drafted. That integral anti fraud personnel requires annual training.

Further, the Commissioner has chosen not to amend (c) (1) change to indicate that insurers may exclude integral anti-fraud personnel and/or SIU staff from this orientation if they receive this training under subparagraph (c) (2) as subsection (c) (1) is specifically applicable to newly hired personnel and requires If an individual falls both within the category of newly hired personnel then they must complete the training within 90 days. Thus, although it would be possible for a person to receive training that complies with 2698.39(c) (2) (integral anti fraud training) that person must also receive such training within 90 days in order to have fully complied with these regulations.

3. The Commissioner has considered AIA's objections that insurance fraud training requirements set forth in the proposed regulations is too broad and creates unrealistic expectations and rejects these comments. After the promulgation of the 1994 regulations regarding SIU's, the Commissioner conducted a series of examinations of insurers to determine the efficacy of the regulations. Examinations of insurers revealed a broad and inconsistent application of training requirements due to the lack of specificity. The proposed regulations seek to address this lack of specificity. The current scheme of three levels of expected training was derived from public workshops and meetings conducted with the industry and industry representatives. The Commissioner believes that the three training levels indicated in the regulations provide the greatest flexibility in designing a training plan that reflects minimum requirements applicable to the duties and functions of the staff indicated. Further, the Commissioner believes the statement of minimum requirements ensures an equitable commitment to training by all insurers.

4. ACIC — The Commissioner has considered the training requirement is too broadly applicable, too costly and that this is regulatory micro-management that serves no valid purpose and rejects it. [See Response to AIA's comment above.]

5. ACLHIC-Regarding section 2698.39(c)(3)(d), the commenter refers to required training that includes "emerging fraud trends" and indicates that ACLHIC views the identification of, and any training regarding, fraud trends within the life industry to be a serious challenge. The Commissioner believes that this comment is insufficiently developed by the commenter to allow response as there is no indication from the commenter what types of challenges are presented.

6. PIFC-The Commissioner has considered and rejected the text changes proposed by PIFC. The Commissioner agrees that the distribution of orientation materials may be a typical procedure instituted by an insurer to train newly hired employees; however, the Commissioner believes that instructions for the orientation of newly hired employees should not contain more detail than the proposed regulations. The Commissioner believes that the addition of this requirement to the proposed subsection would restrict insurers from designing appropriate orientation sessions that are reflective of their own company's practices and procedures. Additionally, the Commissioner believes it is not necessary to delete subparagraph (c) and expand subparagraph (b). Each paragraph requires employees receive orientation regarding a specific subject matter. Subparagraph (a) describes the function and purpose of the SIU and subparagraph (b) describes fraud detection and referral to the SIU and (c) describes more specifically the Fraud Division insurance fraud reporting requirements. The Commissioner believes that each of these areas or subject matters are part of the orientation is essential and should not be eliminated. Removal of the subject matter described in subsection (c) would result in inadequate orientation of newly hired employees. While the Commissioner acknowledges that all newly hired employees do not require the level of training required of SIU personnel, the newly hired employees must have a certain minimal level of knowledge in the event they encounter suspected insurance fraud. The requirements set forth in this subsection are specifically drafted to ensure that upon encountering indicators of suspected insurance fraud a newly hired employee would be aware of the insurer's

procedures for detection and referral of suspected insurance fraud to the SIU for investigation.

Additional changes made by the Commissioner:

1) To provide consistency in the language of subparagraph 2698.37(c) (1), the word training is removed and replaced with the word orientation. The text will read as follows: *All newly-hired employees shall receive an anti-fraud orientation with ninety (90) days of commencing assigned duties. The ~~training~~ orientation shall provide instruction on:*

2) To provide consistency with the definitions, subparagraph (c) (1) (b) will be modified to reference "suspected insurance fraud" rather than "suspect fraudulent claims." The text will read as follows, (b) an overview of fraud detection and referral of suspected ~~fraudulent claims~~ insurance fraud to the SIU for investigation.

Commenter Number

Commenter Name(s): PIFC,
Date of comment:
Type of comment: Written

Summary of comment: PIFC– The commenter indicates the maintenance of records is over burdensome and that it is not clear that the Department wants the insurer to keep records of when they train new hires and then keep records of their training of the new hires. Also in reference to their orientation materials in section, 2698.39(c) the commenter proposes to have the Department recognize the packet of materials as justification for the training of all new personnel and as compliance for the record keeping requirements. These include title and date of training course, name and title and contact information of the instructors, description of the course content, length of the training course and name and job title of the participating personnel. The commenter proposes to amend the text as follows:

Records of the materials provided subject to (c)1 and the training provided subject to (c)(2) and (c)(3) shall be maintained and available for inspection by the Department as specified in this subsection.

(1) For (c) (1) the records shall include a copy of the materials provided and verification of the insurer's method of providing this information.

(2) For (c)(2) and (c)(3) the training records shall include the title and date of the anti-fraud training course, name and title and contact information of the instructor(s), description of the course content, length of the training course, and the name and job title(s) of participating personnel."

Response to comment:

The Commissioner has considered this commenter's objections to subsection 2698.39(c) and rejects the objections.

First, the commenter contends that the maintenance of training records is overly burdensome and that it is not clear that the Department wants the insurer to keep records of when they train new hires and then keep records of their training of the new hires. Although the maintenance of proof of training may create an additional requirement for some insurers not already documenting their training, the Commissioner believes that this requirement is reasonably necessary for the Department to oversee insurer training programs and ensure insurer compliance with training requirements. In order to deter and detect fraud the Commissioner believes it is essential that all newly hired employees receive an anti fraud orientation within ninety days of commencing assigned duties as newly hired employees potentially may have some contact with suspected insurance fraud in the course of their duties, and should this arise, they need to know the appropriate actions to take. The Commissioner believes that the current language of the subsection is clear and provides a method for the insurer to adequately document the required training and provides the Commissioner with a means to fully monitor the insurer's training of new hires. The Commissioner does not find not compelling evidence to modify the current text.

Regarding recognition of PIFC's orientation packet as proof of the completion of orientation, the Commissioner believes that this comment is outside the scope of this proceeding as it is essentially a request for prior approval of a specific protocol and the Commissioner will not address this issue here.

Commenter Number

Commenter Name(s): ACIC, Zenith, SCIF, ACHLIC
Date of comment:
Type of comment: Written

Summary of comment: 2698.40

1. Zenith – refers to 2698.40(b)(8) of the informative digest as a conclusion that a reported number suggests that a company's staffing level is adequate
2. SCIF regarding section 2698.40(d) recommends that this subsection specify who is authorized to review the annual report
3. ACIC –
   (1)-Commenter contends that the report information is for a preceding year and is worthless for planning and allocation of funding for fraud enforcement. Recommends moving the reporting date to March of each calendar year.
   (2)-Recommends that a provision should be made for electronic filing of annual reports by insurers
   (3)-Recommends that consideration should be giving to requiring that annual reports include only information required to be updated by the insurer preparing the report

4. ACLHIC –
(1). 2698.40(b) (10) – The commenter is concerned that "significant, anticipated changes to the insurer's operations" sets forth an overly broad standard absent further clarification and/or specific definition of the type of "changes" which would be applicable.
(2). 2698.40(b) (12) – The commenter feels the number and type of civil actions initiated by a company is a good indication of fraud, however, providing all actions "initiated" puts an additional burden on companies in several areas.

Response to comment:

1. The Commissioner has considered this comment and finds that commenter has made no criticism of the regulatory text nor suggested any change to text. The commenter has only provided criticisms regarding a statement in the Informative Digest that a reported a significant amount of fraud activity suggests that a larger staff is necessary to comply with the regulations. The Commissioner believes that as the statement quoted uses the word "suggests" and has no regulatory effect; it is a mere statement of the Commissioner's opinion and requires no further justification. No automatic consequences flow from reporting a significant amount of fraud activity.

2. The Commissioner has considered and accepts the recommended change. The text will be change to clarify that this subparagraph is in relation to later subsection 2698.41, Examinations. This change clarifies the intent of the availability for review. The text will be changed to read, "The insurer is to maintain a copy of the annual report that will be available for review during examinations as conducted pursuant to section 2698.41 of these regulations or as otherwise requested by the Department"

3. ACIC-
The Commissioner has considered and rejects the commenter's proposed deletion of the requirement of reporting information for the preceding year. The commenter notes that the information is worthless. The Commissioner rejects this contention and notes that even though funding is determined by statute and is not dependent by the data provided on the annual report, the data it is useful in reviewing and determining the efficacy of these regulations, for statistical purposes and overall review of the insurer performance.
(1)The Commissioner has considered and rejects the recommendation to provide for electronic filing of annual reports for the following reasons. These proposed regulations have not yet been adopted or implemented by the regulated entities. Further evidence and justification of the need for such a system would have to be developed, presented and considered in order for an accurate assessment of cost or benefits of such a filing system to be determined.
(2)The Commissioner has considered and rejects ACIC's recommendation that companies only be required to provide updated information and not a complete report every year for the following reasons. First, such a reporting requirement contains no baseline against which to measure changes. The Commissioner believes that effective reporting allows the Commissioner to track and monitor changes that occur over time.

4. ACLHIC-

(1)The Commissioner has considered and accepted ACLHIC's suggested change to 2698.40(b) (10) to provide more clarification; text will be added to include "structure" and operations. The text will read:" A description of any significant, anticipated changes to the insurer's structure and operations."
(2) The Commissioner has considered and rejected ACLHIC's objection to 2698.40(b) (12) as the comment is not fully developed and the Commissioner is unable to determine the objection that ACLHIC proposes. No change will be made.

Commenter Number

Commenter Name(s): SCIF, ACIC
Date of comment:
Type of comment: Written

Summary of comment: 2698.41
1. SCIF – incorporate compliance with AB 1227
2. ACIC –
    1. Recommends adding statement that intended to enable implementation and enforcement of provisions of the IFPA
    2. Recommends adding clarification of examination roles for WC insurers subject to exam by DIR and CDI

Response to comment:
1. SCIF –The Commissioner has considered and rejected SCIF's suggestion that Section 2698.41 should be modified to reflect the newly enacted pertains to the administration of penalties and as such, any changes to these regulations would not be made in this section. Change has been made to 2698.42 – Penalties and a new section 2798.43 – Hearing has been added to address the affect of AB 1227 on these regulations.
2. ACIC –
   (1)Disagree with the change as unnecessary, existing regulations sections 2698.31 and 2698.41 make it clear and we do not find necessity to repeat the reference to the IFPA in this section
   (2)The commencer's concerns are outside scope of rulemaking and the SIU regulations.

Commenter Number

Commenter Name(s): SCIF, ACIC
Date of comment:
Type of comment:

Summary of comment: 2698.42
1. SCIF - recommend update based on AB 1227
2. ACIC - recommend update based on AB 1227

Response to comment:

1. Agree, will amend language
2. Agree, will amend language

The text will be amended to read:
(a) If the Commissioner acts pursuant to the provisions of California Insurance Code Section 1875.24(c) or (d) and finds that the insurer has failed to comply with the provisions of this subchapter, the Commissioner shall impose a monetary penalty in an amount not to exceed $5,000 for each act of non-compliance. Where the Commissioner determines that an insurer has willfully failed to comply with this subchapter, the Commissioner may impose a monetary penalty in an amount not to exceed $ 10,000 for each willful act of non -compliance. The Commissioner shall consider the factors enumerated at California Code of Regulations Title 10 Chapter 5, Subchapter 3,Section 2591.3 (a)-(f) and determine if any of the enumerated factors are applicable to the insurer's conduct in the establishment and operation of its special investigative unit. If the Commissioner finds such factors are applicable to the insurer's conduct, the Commissioner may reduce the amount of the monetary penalty prescribed in subsection 2698.42(a).

(b) If the Commissioner acts pursuant to the provisions of California Insurance Code Section 1875.24(c) or (d) and determines that the acts of non-compliance are inadvertent and are solely relative to the maintenance and operation of the special investigative unit of the insurer, then the Commissioner may consider such violations to be a single act for the purposes of imposition of a monetary penalty that is o greater than $5,000 for that single act. For all other inadvertent acts, the Commissioner may impose a penalty in the amount of up to $5,000 per inadvertent act that is not in compliance with this subchapter.

In addition, applicable definitions will be added to section2 698.30 to read as follows:

(a) "Act" means any violation of California Code of Regulations, Title 10, Chapter 5, Section 2698.30-42, inclusive.
(h) "Inadvertent" means unintentional and outside the control of the insurer.
(r) "Willful" means a purpose or willingness to commit the act or make the omission referred to in the California Insurance Code or in these regulations. It does not require any intent to violate the law or to injure another.

Commenter Number

Commenter Name(s): Department
Date of comment:
Type of comment:

Summary of comment: Section 2698.43, hearing

Response to comment: In response to integrating AB 1227 in the examination and penalties section, the Department is compelled to further specify the regulations

pertaining to hearing as used in these regulations. There fore the following text and section will be added:

Section 2698.42 Hearings

(a) Any hearing conducted pursuant to these regulations shall be governed by the provisions of California Government code Section 11425.10(a)

(b) The Commissioner shall give 30 days written notice of any hearing held pursuant to these regulations.

In addition, an applicable definition will be added to section2698.30 to read as follows:

(h) "Hearing" means an adjudicative proceeding initiated by the Insurance Commissioner pursuant to the provisions of California Insurance Code Section 1875.24(d).

Additional Comments Received During Initial Comment Period That the Commissioner Will Not Respond To -

Commenter: Eric Von Geldern:
Comment Date: November 10, 2004
Type of Comment: Oral (Transcript -Pages 30-6)

Summary of Comment:
This commenter noted the necessity for clear standards to and the necessity for all parties working together in the regulatory process to avoid problems later on.

Response to Comment:
This commenter made no substantive comments that can be responded to other than the general observations stated above;

SUMMARY AND RESPONSE TO PUBLIC COMMENTS RECEIVED PURSUANT TO NOTICE OF REVISED TEXT DATED MARCH 18, 2005

Comment No. 1

Comment Date: March 31, 2005
Commentator: Keesha-Lu M. Mitra
Organization: State Farm Insurance Companies
Type of Comment: Written

Summary of Comment:

Section 2698.30 (r) describes "willful" as being without the element of intent. This is inconsistent with the statutory definition found in 1850.5. The statute defines "willful" as having the "intent" to commit a violation. The proposed regulation should be amended to reflect the statute's definition.

In section 2698.34 (c), the word "than" was mistakenly deleted and should be added to the regulation proposal.

The following are re-writes for section 2698.37 (d) and (e) that are closer interpretations of the intent of the statute:
(d) The immunity granted under California Insurance Code section 1872.5 or other such similar code contained in the Insurance Frauds Prevention Act is applicable in complying with the requirements of this regulation.

(e) Information provided in connection with an investigation under this regulation is subject to the same confidentiality protections contained in the Insurance Frauds Prevention Act.

Response to Comment:

The Commissioner has considered State Farm's comment that the definition of "willful" found at subsection 2698.30 (r) is inconsistent with California Insurance Code Section 1850.9 which requires "intent to commit a violation" And suggests that this regulation be amended so that it so that it is consistent with California Insurance Code Section 1850.9. The Commissioner rejects this comment as it does not accurately reflect California law. California Insurance Code Section 1850.9 is not the controlling statute here. Rather, California Insurance Code Section 1875.24 is the statute that by its own terms expressly controls penalties imposed for violations of these regulations. Pursuant to California Insurance Code Section 1875.24(b), any penalty imposed must be determined as provided in California Code of Regulations Title 10, Chapter 5, and Section 2591.3. These regulations specifically require that the department make a determination of the knowledge or willfulness of a non-compliant act and then subsection 2591.3 (d) (1) (A-E) provides a non- exclusive list of factual situations where acts may be considered willful.

Accordingly, the Commissioner has revised his original definition of willful which first appeared in the Revised Text dated March 18, 2005. The original definition provided that "willful" means: a purpose or willingness to commit the act or omission referred to in the California Insurance Code or these regulations. It does not require any intent to violate law or injure another. After public comment on the Revised Text and based on his own motion, the Commissioner determined that in order to comply with California Code of Regulations Section 2591.3 a more expansive definition of willful was required . Accordingly, in the June 9, 2005 Revised Text the definition willful was revised so that the second sentence was completely deleted and language was added so that the Commissioner was required to use the factors specified in 2591.3 (d)(1)(A-E).The Commissioner believes that the final version of the definition of willful is wholly consistent with California Insurance Code Section 1875.24 and moreover, provides the Commissioner great flexibility in fashioning remedies than either of the previously proposed definitions.

The Commissioner has considered and accepts State Farm's comment regarding section

2698.34 (c), that the word "than" was mistakenly deleted and should be added to the regulation proposal. This word will be added to the June 9, Revised Text.

The Commissioner has considered and rejected the following rewrites of subsections 2698.37(d) and (e).

> (d) The immunity granted under California Insurance Code section 1872.5 or other such similar code contained in the Insurance Frauds Prevention Act is applicable in complying with the requirements of this regulation.
> (e) Information provided in connection with an investigation under this regulation is subject to the same confidentiality protections contained in the Insurance Frauds Prevention Act.

The Commissioner believes that the sections contained in the March 18, 2005 Revised Text are appropriate, properly constructed and legally sound provisions. The Commissioner does not believe, that the versions presented by this commentator are in any way preferable as they do not provide additional clarity and therefore, there will be no changes to this text

Comment No. : 2

Comment Date: April 1, 2005
Commenter: Donna M. Gallagher
Organization: State Compensation Insurance Fund
Type of Comment: Correspondence

Summary of Comments:

The language in section 2698.34 (d) should be changed to include only information which is in the insurer's possession.

In section 2698.42, the proposed changes are inconsistent with the statute 1875.24 (b). The statute states: "violations shall be considered a single act for the purpose of this section," while the new proposed regulation uses the word "may". This expands the Commissioner's discretion beyond the statute's authorization. The word "may" must be changed to "shall".

The addition of the word "solely" unnecessarily increases the likelihood for harsher penalties from inadvertent acts because it forces insurers to prove that an inadvertent act was exclusively related to SIU maintenance and operation. The statute Ins. C. 1875.24 (b) only requires a showing that the inadvertent act was merely "relative to the maintenance and operation (emphasis added)" of the SIU.

Also, in the same section, the proposed regulation is unclear as to what constitutes an act "relative" to the maintenance and operation of the SIU. This creates a discrepancy where carriers are subject to harsher penalties for violations by non-SIU employees and lesser penalties for violations within the SIU itself. Since compliance is easier to achieve among

SIU personnel then among personnel in other departments, there is little justification for the different penalties.

Response to Comment:

The Commissioner has considered and rejected State Farm's comment that the language in Section 2698.34 (d) should be changed to include only information which is in the insurer's possession. Fully effective and timely investigation of suspected insurance fraud requires that the Commissioner have as immediate access as possible to all available information regarding the suspected fraud. While the Commissioner has access to records of his own licensees, the Commissioner's access to other persons records that are not licensees is more difficult to obtain and may require additional time to obtain . Accordingly, the Commissioner has purposefully chosen not to limit records requests to records in the insurer's possession. Instead, the insurer has drafted this regulation to provide that single written request is sufficient to compel production of all information deemed relevant to by the requesting agency and provides that a single request is applicable not only to the insurer, but to all persons employed by and conducting business on behalf of the insurer. In summary the Commissioner believes that the insurer has access to records of all persons that it employs and (by virtue of contractual privity) all persons conducting business on its behalf and therefore, the regulation as drafted is the most efficient and rapid manner for the Commissioner to obtain information.

The Commissioner has considered and accepts this commencer's statement that with respect to section 2698.42, the proposed changes are inconsistent with the statute 1875.24 (b). The statute states: "violations shall be considered a single act for the purpose of this section," while the new proposed regulation uses the word "may." This expands the Commissioner's discretion beyond the statute's authorization. The word "may" must be changed to "shall". Accordingly, the Commissioner will make the suggested change to section 2698.42.

The Commissioner has considered and rejects the commencer's objection that the word "solely" unnecessarily increases the likelihood for harsher penalties from inadvertent acts because it forces insurers to prove that an inadvertent act was exclusively related to SIU maintenance and operation while the statute Ins. C. 1875.24 (b) only requires a showing that the inadvertent act was merely "relative to the maintenance and operation (emphasis added)" of the SIU. The addition of the word "solely" was added for clarification purposes only and does not modify the obligation of the insurer or require the insurer to provide additional proof.

The Commissioner has considered and rejects the commenter's objection that the proposed regulation is unclear as to what constitutes an act "relative" to the maintenance and operation of the SIU. The Commissioner believes that the regulation meets the definition of clarity set forth in the Government Code as it is written using plain English that can be easily understood by the insurer. The Commissioner will not revise this text. With respect to the commenter's other assertions that carriers are subject to harsher penalties for acts by non-SIU employees and lesser penalties for SIU employees, this

statement is untrue, illogical and not supported by either statute or the proposed regulations.

Comment No.: 3

Comment Date: April 4, 2005
Commenter: Jeffrey J. Fuller
Organization: Association of California Insurance Companies
Type of Comment: Written

Section 2698.30 (i) defines "inadvertent" as "outside the control of the (person)." This is not the dictionary definition and should be changed. If it is allowed to remain, every insurer violation would be treated as "intentional" since it would be difficult for them to meet the standard that an act ever was fully outside of their control.

The word "may" must be replaced by "shall" in Sections 2698.42 (a) to conform to the statute Ins. C. 1875.24.

Response to Comment:

The Commissioner has considered ACIC's comment that the words "outside the control of the insurer" should be deleted from the definition of "inadvertent" as it is too difficult a standard to meet. The Commissioner accepts this comment and the words "outside the control" of the insurer will be deleted the definition set forth at 2698.30(i).

The Commissioner has considered ACIC's comment that the word "may" must be replaced by "shall" in Sections 2698.42 (a) to conform to Ins. C. Section 1875.24 and accepts the comment. The word shall replace the word "may" in the referenced section.

Comment No.: 4

Comment Date: April 4, 2005
Commenter: Ted M. Angelo
Organization: Association of California Health Insurance Companies
Type of Comment: Written

Section 2698.30 (r) should use the statutory definition of "willful" found in Ins. C. 1875.24. The statute defines "willful" as having an element of "intent". The current proposed regulation's definition for "willful" lacks this element. It must be changed to conform to the statutory language.

Response to Comment:

The Commissioner has considered ACLHIC's comment regarding the proposed definition of willful. Accordingly the Commissioner has revised his original definition of willful which first appeared in the Revised Text dated March 18, 2005. The original definition provided that "willful" means a purpose or willingness to commit the act or

omission referred to in the California Insurance Code or these regulations. It does not require any intent to violate law or injure another". After public comment on the Revised Text and based on his own motion, the Commissioner determined that in order to comply with the directive contained in California Insurance Code Section 1875.24(b) regarding California Code of Regulations Section 2591.3 a more expansive definition of willful was required . Accordingly, in the June 9, 2005 Revised Text the definition willful was revised so that the second sentence was completely deleted and language was added so that the Commissioner was required to use the factors specified in 2591.3 (d)(1)(A-E). The Commissioner believes that the final version of the definition of willful is wholly consistent with California Insurance Code Section 1875.24 and moreover, provides the Commissioner great flexibility in fashioning remedies than either of the previously provided.

Comment No.: 5

Comment Date: April 4, 2005
Commenter: Michael A. Gunning
Organization: Personal Insurance Federation of California
Type of Comment: Written

In Section 2698.30 (I), the phrase "outside the control of the insurer" should be deleted because it punishes the insurer even if they have no control over events that lead to acts of non-compliance.

PIFC also wishes to see section 2698.34 changed to allow only "specific contact person(s)" to receive requests for information who are responsible for record requests. PIFC won't be able to effectively enforce compliance with "persons" doing business with them unless it is in response to specific records relating to the business conducted on their behalf.

Regarding section 2698.37 (d) and (e), the language on "immunity" should include clearer language to make the intent more clear.

Response to Comment:

The Commissioner has considered PIFC's comment regarding Section 2698.30 (i) that, the phrase "outside the control of the insurer" should be deleted because it punishes the insurer even if they have no control over events that lead to acts of non-compliance. The Commissioner has accepted this comment and as indicated above in response to the other comments on this subsection and has revised the definition of inadvertent to exclude the referenced language.

The Commissioner has considered PIFC's suggestion that section 2698.34 changed to allow only "specific contact person(s)" to receive requests for information who are responsible for record requests. PIFC states that it will not be able to effectively enforce compliance with "persons" doing business with them unless it is in response to specific records relating to the business conducted on their behalf. The Commissioner rejects

PIFC's request to allow only "specific contact persons to receive requests for information. Numerous commentators during the initial public comment period vigorously opposed this proposal. Among these objections posited was that:

1) the single point of contact is unnecessary as the current Department form already contains a line asking for a "contact person" and that routing requests to a single point of contact will require additional insurer time to provide a response;
2) That having the "single point of contact" for the insurer is unnecessary micromanagement; and,
3) the existing procedure for requesting information is routine and continual between insurer SIU's and the Fraud Division; and
4) that the single point of contact does not address the department's actions should a request be sent to the incorrect individual.

For these reasons, the Commissioner deleted the language requiring a single point of contact as set forth in 2698.34(d). The Commissioner has now considered PIFC's request for such a single point of contact and although there is merit to PIFC's comment that it would enable PIFC to effectively enforce compliance with persons doing business with them on balance, the Commissioner believes that the omission of the single point of contact is best because of the difficulties with such a system as described by the initial commenter.

The Commissioner has considered and rejected PIFC's suggestion to amend the provisions set forth at 2698.37 (d) and (e).

[See Response To State Farm Comment No. 1].

SUMMARY AND RESPONSE TO PUBLIC COMMENTS RECEIVED PURSUANT TO NOTICE OF REVISED TEXT DATED JUNE 9, 2005

Commenter Name(s): PIFC
Date of comment: June 27, 2005
Type of comment: Written

This commenter made the following comments:

1. This commenter notes that Section 2698.34 (d) may raise privacy issues regarding employee records.

2. The commenter notes that worker's compensation and property casualty insurance lines require separate treatment. Further the commenter notes that the addition of authority citations to 2698.30 in the June 9, 2005 Revised Text compels the Insurance Commissioner to treat the worker's compensation and property casualty insurance lines differently. In particular, the commenter quotes from California Insurance Code Section 1879. 4(a) and notes that this statute recognizes a distinction between investigating

insurance fraud and worker's compensation fraud and that therefore the regulations should make a similar distinction.

3. The commenter notes that the revision of 2698.(42)(b) that replaces the word "may" with "shall" now requires that the civil penalty for inadvertent violations is now automatically $5,000 per violation. The commenter believes that such a result is contrary to the enabling statute.

Response to Comment:

1. The Commissioner rejects this commenter's comments regarding proposed section 2698. 34 (d) as it is outside the scope of the text changes indicated in the June 9, 2005.

2. The Commissioner has considered and rejects this commenter's assertion that the addition of California Insurance Code Section 1879.4 to the authority citation (contained in the note following section 2698.30) compels the conclusion that the Insurance Commissioner should rewrite the regulations to distinguish between worker's compensation insurance fraud and property casualty insurance fraud. While the cited statute does mention both worker's compensation insurance fraud and insurance fraud, this distinction alone, does not serve as justification for redrafting this entire set of regulations. Further as previously noted by the Commissioner, two sets of regulations would be unduly cumbersome and difficult to draft and enforce.

3. The Commissioner has considered and. rejected the commenter's statement that the revision of 2698.(42)(b) that replaces the word" may" with "shall" now requires that the civil penalty for inadvertent violations is now automatically $5,000 per violation and as such violates the enabling statute.. The commenter has misunderstood the enabling statute found at California Insurance Code Section 1875.24 (b). This statute specifically provides that as follows:

> (b) Any insurer that fails to comply with the provisions of this article or with the regulations ….shall be liable to the state for a **civil penalty not to exceed $ 5,000,for each act, or if the act is willful not to exceed $10,000 for each act.** Subsection 2698.42(b) mirrors this language and it is unclear how the commenter concluded that civil penalty for inadvertent violations is now automatically $5,000 per violation.

As indicated by the bolded language, the statute and regulation are entirely consistent and do not require an automatic penalty without mitigation for either inadvertent or willful acts. The Commissioner will make no change to this section.